



STATE OF ARIZONA  
 BOARD OF BEHAVIORAL HEALTH EXAMINERS  
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DOUGLAS A. DUCEY  
 Governor

TOBI ZAVALA  
 Executive Director

## APPLICATION FOR ASSOCIATE MARRIAGE AND FAMILY THERAPIST LICENSURE

### PART I. PERSONAL INFORMATION

SOCIAL SECURITY NUMBER (MANDATORY)	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr.				
LEGAL NAME	LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN
ALL OTHER NAME(S) OR ALIASES YOU HAVE BEEN KNOWN BY		CURRENT AZ BOARD LICENSE #		
HOME ADDRESS			HOME PHONE	
CITY	STATE	ZIP	CELL PHONE	

**NOTE:** You must provide the Board with addresses and telephone numbers for all employers. Address and telephone information for the primary employer (below) becomes public information. **If you do not provide employer information, your home address and telephone number will become public information.** Please list additional employers on a separate sheet as needed.

AGENCY EMPLOYED BY	<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> INDEPENDENT	<input type="checkbox"/> OTHER _____
POSITION HELD			
BUSINESS ADDRESS			
CITY	STATE	ZIP	BUSINESS PHONE
PREFERRED E-MAIL ADDRESS			FAX NUMBER

Are you requesting special accommodations under the Americans With Disabilities Act (ADA) for taking the required examination?     YES     NO

## **PART II. LEGAL RESIDENCY**

Arizona Revised Statutes § 41-1080 requires, in general, that a person applying for a license must submit documentation to the licensing agency that satisfactorily demonstrates that the applicant is lawfully present in the United States.

### **Section 1. Citizenship or national status declaration**

1. Are you a citizen or national of the United States?  Yes  No (if no, complete Section 2)
- If yes, attach a legible copy of the front and back (if applicable) of your proof of citizenship document. To view a list of acceptable documents, see List A in the Application Resource Guide.
  - Name of document provided: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### **Section 2. Alien status declaration**

For applicants who are NOT citizens or nationals of the United States, please indicate alien status by checking the appropriate box below. Attach a legible copy of the front and back (if applicable) of a document that evidences your status. To view a list of acceptable documents, see List B in the Application Resource Guide.

- Name of document provided: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

#### **“Qualified Alien” Status (8 U.S.C. §§ 1621(a)(1), -1641(b) and (c))**

- 1. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA).
- 2. An alien who is granted asylum under Section 208 of the INA.
- 3. A refugee admitted to the United States under Section 207 of the INA.
- 4. An alien paroled into the United States for at least one year under Section 212(d)(5) of the INA.
- 5. An alien whose deportation is being withheld under Section 243(h) of the INA.
- 6. An alien granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
- 7. An alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).
- 8. An alien who is, or whose child or child’s parent is a “battered alien” or an alien subjected to extreme cruelty in the United States.

#### **Nonimmigrant Status (8 U.S.C. § 1621(a)(2))**

- 9. A nonimmigrant under the Immigration and Nationality Act [8 U.S.C. § 1101 et seq.] Nonimmigrants are persons who have temporary status for a specific purpose. See 8 U.S.C. § 1101(a)(15).

#### **Alien Paroled into the United States For Less Than One Year (8 U.S.C. § 1621(a)(3))**

- 10. An alien paroled into the United States for less than one year under Section 212(d)(5) of the INA

#### **Other Persons (8 U.S.C. § 1621(c)(2)(A) and (C))**

- 11. A nonimmigrant whose visa for entry is related to employment in the United States, or
- 12. A citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99-239 or 99-658 (or a successor provision) is in effect [Freely Associated States include the Republic of the Marshall Islands, Republic of Palau and the Federate States of Micronesia, 48 U.S.C. § 1901 *et seq.*];
- 13. A foreign national not physically present in the United States.

#### **Otherwise Lawfully Present (A.R.S. § 41-1080)**

- 14. A person not described in categories 1–13 who is otherwise lawfully present in the United States.  
**PLEASE NOTE: The federal Personal Responsibility and Work Opportunity Reconciliation Act may make persons who fall into this category ineligible for licensure. See 8 U.S.C. § 1621(a).**

### **Section 3. Declaration**

I declare under penalty of perjury under the laws of the State of Arizona that the answers and evidence I have given are true and correct to the best of my knowledge.

\_\_\_\_\_  
Applicant Signature\_\_\_\_\_  
Date

**PART III. EDUCATION INFORMATION**

Starting with your undergraduate education, list **all** colleges and universities attended, whether completed or not, in chronological order.

COLLEGE OR UNIVERSITY (undergraduate and graduate)	LOCATION (City, State or Country)	DATES ATTENDED (Month/Yr to Month/Yr)	DEGREE EARNED (and date earned)	MAJOR

**PART III, Section 1. OFFICIAL TRANSCRIPTS**

You must include an official transcript for all education being submitted to meet requirements in a **SEALED** envelope from the educational institution. Transcripts submitted in open envelopes will not be accepted.

**A. REQUIRED DEGREE CREDIT HOURS**

Applicants for marriage and family therapist licensure shall have a master’s or higher degree from a regionally accredited college or university in a behavioral health science program.

My graduate program consisted of (choose one):  \_\_\_\_\_ semester credit hours  \_\_\_\_\_ quarter credit hours

College or University: \_\_\_\_\_

Degree Title (as indicated on transcript): \_\_\_\_\_

Date degree awarded: \_\_\_\_\_

**B. ACCREDITATION OF GRADUATE MARRIAGE AND FAMILY THERAPY PROGRAM**

*NOTE: Complete for the behavioral health science degree listed above.*

Please select which of the following designations your graduate program held on the date your degree was awarded:

- 1. Accreditation from the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)
- 2. A Board approved curriculum pursuant to A.R.S. § 32-3253(14) as indicated on the Board’s website
- 3. Neither of the above

What is the approval/accreditation date for the designation indicated in (B)(1-2) above? \_\_\_\_\_



**APPLICANTS SELECTING (B)(1-2) ABOVE PROCEED TO PART IV - BACKGROUND INFO.**

**APPLICANTS SELECTING (B)(3) ABOVE PROCEED TO PART III, Section 2. – CURRICULUM.**

**PART III, Section 2. CURRICULUM**

Not required for applicants whose graduate degree held a designation indicated in (B)(1-2) in Section 1 above at the time of graduation. For curriculum requirements, please see the Application Resource Guide.

**Part A: TO BE COMPLETED BY APPLICANT**

Indicate all courses taken that fulfill the requirements for the six core content areas as defined in R4-6-601(B). For each core content area, list ALL courses that meet the requirement. However, each course may only be used to meet a single area. Do not list the same course in more than one area unless indicating embedded coursework.

Please submit published college or university course descriptions for the year and semester you were enrolled for every course you submit to meet the curriculum requirements. Please highlight the courses you are using to meet curriculum requirements. To assist in the review process, applicants are strongly encouraged to include syllabi for the core content area coursework from the year/semester attended.

A course must be a 3-semester or 4-quarter credit hour course to count for licensure purposes.

					<b>FOR COMMITTEE USE ONLY.</b>			
<b>CORE CONTENT AREA</b>	<b>COURSE NO.</b>	<b>COURSE NAME</b>	<b>TERM/ YEAR CMPL</b>	<b>CREDITS (Sem / Qtr)</b>	<b>ELEMENTS COVERED</b>	<b>Review #1</b>	<b>Review #2</b>	<b>Curriculum Requirement Met?</b>
<b>Marriage and Family Studies</b> - Three courses from a family systems theory orientation that collectively contain at minimum the following elements:  a. Introductory family systems theory b. Family development c. Family systems, including marital, sibling, and individual subsystems, and d. Gender and cultural issues					a b c d			
					a b c d			
					a b c d			
					a b c d			
					a b c d			
<b>Marriage and Family Therapy</b> - Three courses that collectively contain at minimum the following elements:  a. Advanced family systems theory and interventions b. Major systemic marriage and family therapy treatment approaches c. Communications, and d. Sex therapy					a b c d			
					a b c d			
					a b c d			
					a b c d			
					a b c d			
<b>Human development</b> - Three courses that may integrate family systems theory that collectively contain at minimum the following elements:  a. Normal and abnormal human development b. Human sexuality, and c. Psychopathology and abnormal behavior					a b c			
					a b c			
					a b c			
					a b c			
					a b c			

					<b>FOR COMMITTEE USE ONLY.</b>			
<b>CORE CONTENT AREA</b>	<b>COURSE NO.</b>	<b>COURSE NAME</b>	<b>TERM/ YEAR CMPL</b>	<b>CREDITS (Sem / Qtr)</b>	<b>ELEMENTS COVERED</b>	<b>Review #1</b>	<b>Review #2</b>	<b>Curriculum Requirement Met?</b>
<b>Professional Studies</b> - One course including at minimum:  a. Professional ethics as a therapist, including legal and ethical responsibilities and liabilities, and b. Family law					a b			
					a b			
					a b			
					a b			
					a b			
					a b			
<b>Research</b> - One course in research design, methodology, and statistics in behavioral health science								
<b>Supervised Practicum</b> - Two courses that supplement the practical experience requirements								
<p>In addition to required practicum course work, the supervised practicum must provide an enrolled student the opportunity to provide marriage and family therapy services to individuals, couples and families in an educational or professional setting under the direction of a faculty member or supervisor designated by the college or university. It must include 300 client-contact hours provided under direct supervision by a licensed marriage and family therapist. Please complete Parts 2 and 3 below with this information.</p>								

**Part B: VERIFICATION OF PRACTICUM**

NOTE: Applicant must mail this form to the college/university for verification before submission to the Board.

**TO BE COMPLETED BY THE APPLICANT**

To: \_\_\_\_\_  
University (please print)

Applicant's SSN: \_\_\_\_\_

From: \_\_\_\_\_  
Applicant's name (please print)

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Applicant's Address

Briefly describe practicum setting and your activities: \_\_\_\_\_

\_\_\_\_\_

Supervision of the practicum must have been done under the direction of a college/university designated faculty member or supervisor with an active Marriage and Family Therapist license.<sup>1</sup> Please indicate the faculty member or supervisor providing supervision and their license below:

Practicum Supervisor: \_\_\_\_\_  Faculty member  Site Supervisor

MFT license number<sup>2</sup>: \_\_\_\_\_

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. I hereby authorize you to release the information requested below.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY THE COLLEGE/UNIVERSITY**

NOTE: After completing this verification form, college/university personnel must send this verification form back to the applicant for submission with their application.

Applicant's Name: \_\_\_\_\_

**College/University Verification**

I attest that the applicant completed a supervised practicum, field work experience, or internship in a professional setting under the direction and supervision of a faculty member and/or site supervisor holding a Marriage and Family Therapist license, and approved by the college/university as follows:

Dates of participation: From \_\_\_\_\_ To \_\_\_\_\_

Total hours of client contact during practicum: \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
College/University name

\_\_\_\_\_  
Telephone number

College/University seal

<sup>1</sup> If the practicum supervisor was not a licensed MFT, applicant must submit a written request for an exemption and attach the proposed practicum supervisor's transcript, curriculum vitae, and Verification of Credential form (see page 7) if the supervisor was not licensed by the Board.

<sup>2</sup> If the MFT license is held in a state OTHER than Arizona, please provide a Verification of Credential form (see page 7).

**Part C. VERIFICATION OF PRACTICUM SUPERVISOR’S CREDENTIALS**  
 (Not required if the Practicum Supervisor held an active license from the Board)

If your Practicum Supervisor did not hold an active license by the Arizona Board of Behavioral Health Examiners, you must submit verification of their credential(s) from the regulatory entity in which they are licensed or certified.

Title of Practicum Supervisor’s Credential Held	State	Date Issued	Expiration Date	Credential #	Current Status

For all credentials listed above, attach a verification from the regulatory entity issuing the credential. The verification must include the following information:

- Professional’s name
- Credential title and number (if applicable)
- Credential issue and expiration date
- Credential status
- Past disciplinary actions

Applicants may use an online verification if it contains all required items above and is printed from the regulatory entity’s official website. If not, applicant must request an official verification from the regulatory entity and attach it to this application.

## **PART IV. BACKGROUND QUESTIONNAIRE**

If the answer to any of the questions below is “YES”, provide a complete explanation below.

<b>QUESTIONS</b>		
1.	Have you ever been denied a license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Other than complaints filed by this Board, have you ever been or are you currently the subject of any complaint, investigation or disciplinary action against your license, certificate, registration or membership by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state? If yes, please provide copies of the complaint and all final actions.	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Have you ever voluntarily surrendered, allowed to lapse, canceled or resigned your license, certificate, registration or membership in lieu of disciplinary proceedings or sanctions of any kind by any state regulatory board, any professional or occupational credentialing authority or any professional association in Arizona or any other state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	Have you <b>ever</b> been arrested, charged with, convicted of or pled nolo contendere to a criminal offense, other than a minor traffic violation (DUI history must be reported), in any city, county, state, federal or tribal court, or in any other country? If yes, please provide copies of the police and court documents such as the police narrative, complaint, the pleadings and final order(s). <b><u>You must answer “yes” even if you received a pardon, the charges were dropped, the conviction was set aside, the records were expunged, or your civil rights were restored.</u></b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Have you ever entered into any type of pretrial diversion or deferred prosecution agreement with a state or federal government? If yes, please provide a copy of your pretrial diversion agreement.	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Have you ever been or are you currently a defendant in any type of civil or criminal action related to any professional services (i.e., malpractice)? If so, indicate whether you entered into a settlement agreement or were ordered to pay damages and whether such a suit is currently pending. Provide copies of the original complaint and response, any judgment entered and any settlement agreements.	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Have you ever had any disciplinary action or sanctions of any kind taken against you by any behavioral health related employer in Arizona or any other state? If yes, please provide the name, address and telephone number of the employer, the name of your immediate supervisor and a description of the cause for disciplinary action or sanction.	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Have you ever been involuntarily terminated or resigned in lieu of termination from any behavioral health position or related employment? If yes, please provide the name, address and telephone number of the employer, the name of your immediate supervisor and a description of the cause for the termination. If the cause of termination was due to a reduction in force, please include a copy of the letter advising you of the layoff.	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>CONFIDENTIAL QUESTION</b>		
9.	Have you received treatment within the last five years for use of alcohol or a controlled substance, prescription-only drug, or dangerous drug or narcotic, or a physical, mental, emotional, or nervous disorder or condition that currently affects your ability to competently and safely perform the essential functions of your profession? If so, provide the following: a. A detailed description of the use, disorder, or condition; and b. An explanation of whether the use, disorder, or condition is reduced or ameliorated because you’re receiving ongoing treatment and if so, the name and contact information for all current treatment providers and for all monitoring or support programs in which you are currently participating. c. A copy of any public or confidential agreement or order relating to the use, disorder, or condition, issued by a licensing agency or health care institution within the last five years, if applicable.	<input type="checkbox"/> YES <input type="checkbox"/> NO





## PART V. EMPLOYMENT HISTORY

Provide all employment for the previous ten years including an explanation of any breaks in employment of greater than one month. Copy sheet as needed.

<b>PRESENT EMPLOYMENT</b>	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
<b>REASON FOR LEAVING:</b>	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	
<b>PRIOR EMPLOYMENT</b>	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
<b>REASON FOR LEAVING:</b>	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	
<b>PRIOR EMPLOYMENT</b>	JOB TITLE	MM/DD/YY TO MM/DD/YY
NAME OF BUSINESS OR INSTITUTION (AGENCY OR ORGANIZATION) <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> INDEPENDENT CONTRACTOR <input type="checkbox"/> OTHER _____		
ADDRESS		
CITY, STATE, ZIP		TELEPHONE
NAME AND TITLE OF SUPERVISOR		
DESCRIPTION OF DUTIES PERFORMED		
<b>REASON FOR LEAVING:</b>	<input type="checkbox"/> RESIGNED – NEW POSITION	<input type="checkbox"/> RESIGNATION – OTHER (EXPLAIN)
<input type="checkbox"/> TERMINATION (EXPLAIN)	<input type="checkbox"/> RESIGNED IN LIEU OF TERMINATION (EXPLAIN)	

**PART VI. EXAM INFORMATION**

Have you previously passed the examination required for the license you are applying for in Arizona?  Yes  No

If yes, you must request an official copy of your score report be forwarded to the Board from AMFTRB.

If not, you will be provided testing information once authorized to test.

**PART VII. FEDERAL DATA BANK SELF-QUERY**

The National Practitioner Data Bank (NPDB) retains information on behavioral health professionals. A self-query from NPDB is required to process your application. The self-query cannot be dated more than 90 days prior to applying for licensure, and must be submitted in an unopened envelope from the databank.

For information on obtaining your self-query, please visit [www.npdb.hrsa.gov](http://www.npdb.hrsa.gov) or contact the NPDB Customer Service Center at 1-800-767-6732.

**I have attached a self-query in an unopened envelope that is dated not more than 90 days prior to my application.**

**PART VIII. PROFESSIONAL CREDENTIALS**

Please list current or previous licenses or certifications issued by a state regulatory entity held as follows: any license or certification ever held in the practice of behavioral health; and any professional license or certification NOT in the practice of behavioral health held in the last ten years. Failure to disclose all licenses, certifications or registrations as required above may result in denial of your application or other appropriate action. It is not necessary to list licenses issued by the Board.

Title of Credential Held	State	Date Issued	Expiration Date	Credential #	Current Status

For all credentials listed above, attach a verification from the regulatory entity issuing the credential. The verification must include the following information:

- Professional’s name
- Credential title and number (if applicable)
- Credential issue and expiration date
- Credential status
- Whether there are pending complaints
- Past disciplinary actions

Applicants may use an online verification if it contains all required items above. If not, applicant must obtain verification from the regulatory entity using the form in **PART VIII, Section 1**.

**PART VIII, Section 1. VERIFICATION OF CREDENTIALS**

NOTE: Applicant will submit one completed form for EACH credential listed in **PART VIII**. An applicant may submit an online verification as long as ALL required information is included on the official state website verification.

**Part A: TO BE COMPLETED BY THE APPLICANT**

To: \_\_\_\_\_  
State Regulatory Agency (please print)

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

From: \_\_\_\_\_  
Applicant's Name (please print) Telephone

\_\_\_\_\_  
Applicant's Address

I have applied to the Arizona Board of Behavioral Health Examiners for licensure as a behavioral health professional. I hereby authorize you to release the information requested below.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**THE APPLICANT MUST MAIL THIS FORM TO THE APPROPRIATE STATE CREDENTIALING AGENCY FOR VERIFICATION BEFORE SUBMISSION TO THE ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS**

**Part B: TO BE COMPLETED BY THE STATE CREDENTIALING AGENCY**

Professional's Name \_\_\_\_\_

Credential Held \_\_\_\_\_

Credential Number \_\_\_\_\_

Issuance Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

Current Status \_\_\_\_\_

Pending Complaints  YES  NO

Number of Past Disciplinary Actions \_\_\_\_\_

Pending complaints are not public information in our jurisdiction

Attach explanation of all disciplinary actions.

\_\_\_\_\_  
Form Completed By Date

Please Include State Seal

\_\_\_\_\_  
Credentialing Agency Name and Phone Number

**PART IX. CERTIFYING STATEMENT**

I give my permission for the Arizona Board of Behavioral Health Examiners ("Board") to secure additional information concerning me or my statements in this application from any person or source the Board deems necessary. My signature below authorizes entities in possession of applicable information to release such information to the Board.

I will notify the Board in writing within 10 working days if charged with a misdemeanor that may affect patient safety or a felony pursuant to A.R.S. § 32-3208. Additionally, I will report to the Board any updates to the information provided in this application after submission including, but not limited to: contact information, employment changes, and answers to background information questions.

I certify that by submitting this application for licensure, I have read and understand the Board's rules and statutes and agree to abide by them as an applicant and as a licensee in the event I am approved for licensure.

I, \_\_\_\_\_ certify under penalty of perjury that all information contained in my application, including all supporting documents, is true and correct to the best of my knowledge and belief, and with full knowledge that any false statements or misrepresentations made in this application may be grounds for refusal, subsequent revocation or suspension of my license(s), or other disciplinary action.

\_\_\_\_\_  
Signature of Applicant  
*(must be signed in front of a notary)*

\_\_\_\_\_  
Date

<b>TO BE COMPLETED BY NOTARY</b>	
Subscribed and sworn before me this _____ day of _____, 20____, in the State	
of _____ and County of _____.	
Notary Public _____	My Commission Expires _____
Notary Seal	

## ***IS MY APPLICATION READY TO SUBMIT?***

### **I HAVE INCLUDED ALL OF THE FOLLOWING DOCUMENTS:**

- Completed Application Form
- Non-refundable application fee of **\$250.00** (money order, certified or cashier’s check, or proof of online credit card payment accepted). If you are also sending payment for a criminal history background check, they may NOT be combined into one payment.
- A copy of legal document establishing legal residency (if not already on file and still current)
- A copy of my driver’s license, state-issued ID or social security card
- A copy of my current DPS fingerprint clearance card (front and back), or a complete set of fingerprints on a card obtained from the Board (if not already on file). If submitting a complete set of fingerprints, you must include a payment of **\$40.00** for the criminal history background check (personal check, money order, certified or cashier’s check, or proof of online credit card payment accepted). **NO PAYMENT** is needed with a current DPS fingerprint clearance card.
- An official transcript **in a sealed envelope**
- Data bank report (self-query) **in a sealed envelope from the data bank**
- Verification of professional credentials

### **SUBMIT TO:**

#### **Arizona Board of Behavioral Health Examiners**

1740 West Adams St., Suite 3600

Phoenix, Arizona 85007

Office Hours: Monday – Friday 8:00 am to 5:00 pm, excluding state holidays

### **FOLLOWING SUBMISSION:**

- Confirm receipt of the application on the Board’s website by:
  - Clicking on “Verifications,” then “Check for pending applications”
  - Search by your last name. Your application will display as “Pending” if received
- Staff will provide updates on the progress of your application including when your application is administratively and substantively complete, if additional information is needed, and next steps in the process
- Staff will notify you of any Committee or Board meetings at which your application will be reviewed
- If applicable, staff will provide information on taking an exam required for licensure
- Staff will direct you how/when to send your issuance fee once you have been recommended for licensure
- You must notify the Board if any information provided in the application changes including, but not limited to:
  - Contact information
  - Employment changes
  - Answers to background information questions.
- You must notify the Board in writing within 10 working days if charged with a misdemeanor that may affect patient safety or a felony pursuant to A.R.S. § 32-3208

Pursuant to A.R.S. § 41-1030, the following information must accompany all license applications.

**41-1030. Invalidity of rules not made according to this chapter; prohibited agency action; prohibited acts by state employees; enforcement; notice**

- A. A rule is invalid unless it is made and approved in substantial compliance with sections 41-1021 through 41-1029 and articles 4, 4.1 and 5 of this chapter, unless otherwise provided by law.
- B. An agency shall not base a licensing decision in whole or in part on a licensing requirement or condition that is not specifically authorized by statute, rule or state tribal gaming compact. A general grant of authority in statute does not constitute a basis for imposing a licensing requirement or condition unless a rule is made pursuant to that general grant of authority that specifically authorizes the requirement or condition.
- C. An agency shall not:
1. Make a rule under a specific grant of rulemaking authority that exceeds the subject matter areas listed in the specific statute authorizing the rule.
  2. Make a rule under a general grant of rulemaking authority to supplement a more specific grant of rulemaking authority.
- D. This section may be enforced in a private civil action and relief may be awarded against the state. The court may award reasonable attorney fees, damages and all fees associated with the license application to a party that prevails in an action against the state for a violation of this section.
- E. A state employee may not intentionally or knowingly violate this section. A violation of this section is cause for disciplinary action or dismissal pursuant to the Agency's adopted personnel policy.
- F. This section does not abrogate the immunity provided by section 12-820.01 or 12-820.02.
- G. An agency shall prominently print the provisions of subsections B, D, E and F of this section on all license applications, except license applications processed by the corporation commission.
- H. The licensing application may be in either print or electronic format.